News Release

Congressman George Miller

7th District, Calif. Senior Democrat, Committee on Education and the Workforce.
Member, Committee on Resources. **www.house.gov/georgemiller/**

FOR IMMEDIATE RELEASE: CONTACT: Daniel Weiss
Wednesday, July 16, 2003 202/225-2095

MILLER TO HOLD PRESCRIPTION DRUG TOWN MEETINGS

Part of national effort to educate seniors and disabled on proposed changes to Medicare prescription drug coverage

WASHINGTON – Congressman George Miller (D-Martinez) will hold two town meetings in Concord and Vallejo this **Saturday, July 19, 2003 on proposed prescription drug coverage through Medicare for seniors and people with disabilities.** Major changes are under consideration in Washington that will have far-reaching implications for Medicare and the people who depend on it.

Saturday's town meetings are part of a national effort to educate seniors and people with disabilities on how proposed changes to Medicare will impact them and their families. Events are being held in over eighty congressional districts around the country.

Please note that all locations are wheelchair accessible. For special accommodations, please call (925) 602-1880.

WHO: **Congressman George Miller (D-Martinez)**

WHAT: **Prescription Drug Town Meetings**

WHERE: **9:00am – 10:00am Vallejo Community Center**
225 Amador Street (at Georgia Street)

11:00am – Noon Concord Senior Center
2727 Parkside Circle (at Bonifacio Street)

WHEN: **SATURDAY, July 19, 2003**

Both locations are wheelchair accessible

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Office of Democratic Leader Nancy Pelosi

June 26, 2003

H.R. 1, HOUSE GOP PRESCRIPTION DRUG BILL

Designed to Help HMOs, Not Seniors

"To those who say that [the GOP bill] would end Medicare as we know it, our answer is: We certainly hope so."

– Rep. Bill Thomas, MSNBC, 6/25/03

Today, the House will consider H.R. 1, the House GOP prescription drug bill. **Democratic Members are urged to vote NO on this deeply flawed bill** that fails to give seniors an affordable, guaranteed drug benefit and also ends Medicare as we know it in 2010.

Democrats have been fighting for years for a Medicare prescription drug program that is affordable; available to all seniors and disabled Medicare beneficiaries; offers meaningful, guaranteed benefits; and is offered within the traditional Medicare program. In contrast, this House GOP bill does not make prescription drugs affordable, does not guarantee that the benefit will be available to seniors in rural areas, does not offer a meaningful plan with guaranteed costs and benefits; and does not give seniors the option of obtaining their prescription drug coverage through traditional Medicare.

The House GOP bill is significantly worse than the Senate Finance bill and goes even further toward privatizing Medicare than the legislation 199 Democrats opposed last year.

The House GOP plan would be run by HMOs and the private insurance industry, not Medicare. The House GOP bill does not even give seniors the option of selecting a prescription drug benefit under the traditional Medicare program. Instead, seniors would be forced to use HMOs and private insurance companies for drug coverage rather than Medicare. While House Republicans are *estimating* their premium at $35, the fact is that private insurance companies and managed care plans would design the new prescription drug plans, decide what to charge, and even decide which drugs seniors would get. Plus, private insurance plans would only have to promise to stay in the program for one year. That means that seniors might have to change plans, change doctors, and even change the drugs they take every 12 months.

The House GOP bill does not make drugs affordable for seniors. Under the House GOP plan, many seniors would be required to pay high premiums even when they don't receive benefits. Under the House GOP bill, Medicare beneficiaries would have to buy their first $250 worth of drugs without any federal help, then would pay 20 percent of all of their drug costs from $251 to $2,000 a year. Then the Republican plan would again *offer no help at all* until a senior's annual drug costs reached $4,900 (the

bill's $3,500 out-of-pocket cap translates into $4,900 in total drug costs). 47% of Medicare beneficiaries would fall into this "coverage gap" every year, while still paying the monthly premium. According to the AARP's John Rother, seniors "don't understand why coverage would end just when they need it most. They interpret it as some kind of trick." (Wall Street Journal, 6/9/03) Indeed, in its June 25th letter, AARP points out *"This gap remains among [beneficiaries'] top concerns. It is not good policy, is unnecessarily confusing, and will prove to be a disincentive to enrollment. We urge you to close this coverage gap."*

The House GOP bill does not offer guaranteed benefits now - and by 2010 would offer seniors only a voucher. Unlike the Senate bill, the House GOP plan is specifically designed to privatize the entire Medicare program. Indeed, on June 25, Rep. Bill Thomas stated exactly that: "To those who say that [the GOP bill] would end Medicare as we know it, our answer is: We certainly hope so." Not only is the new prescription drug benefit run by private insurance companies, but traditional Medicare itself would soon "wither on the vine." Under the GOP "premium support" provision tacked onto the prescription drug legislation, millions of seniors who want to stay in traditional Medicare would be required to pay much more than they do now – essentially forcing them into HMOs and other private plans. As the AARP has pointed out, *"The provision that would establish a premium support structure beginning in 2010 could destabilize the traditional Medicare program and lead to much higher costs for beneficiaries. ... Rather than expand choice, this provision could limit choice by leading to substantially higher costs for beneficiaries who want to stay in the traditional Medicare program. Those who choose not to enroll in private plans should not be put at a financial disadvantage."*

The House GOP bill disadvantages seniors in rural areas - and many others. By creating different regions with different rules, and relying on private insurance plans to offer coverage, the Republican approach does not guarantee the same benefits for seniors in rural communities, where millions of elderly and disabled Americans have already been abandoned by managed care plans in search of bigger profits elsewhere. (Indeed, because of all the plan withdrawals, currently, four out of five seniors in rural areas have no access to a managed care plan under the existing Medicare HMO program.) Seniors where hospitals and doctors negotiate lucrative contracts with managed care plans would have to pay more, seniors with higher incomes would have to pay more, seniors in rural areas would have fewer choices of doctors and pharmacies, and seniors with low incomes but with assets such as a savings account might get nothing at all. These provisions violate the central promise of Medicare: a consistent benefit that guarantees access to everyone no matter where they live, how much income they have, or how sick they are.

The House GOP bill undermines the universal character of Medicare – providing different benefits to different seniors depending on their income. Unlike the Senate Finance bill, the House GOP bill contains a "means-testing" provision. For higher-income seniors (defined as those with incomes of $60,000 for an individual and $120,000 for a couple), catastrophic coverage would kick in at thresholds higher than the bill's $3,500 in out-of-pocket expenditures – with a threshold of up to $13,200 for the wealthiest beneficiaries. Means-testing violates the central promise of Medicare – a consistent benefit for everyone. As AARP has pointed out, *"Medicare has always been and must remain a social insurance program. Altering the catastrophic coverage benefit based on beneficiary income would erode the universal nature of the program. ... Weakening this social contract – even if it at first only narrowly affects higher income beneficiaries – threatens to move the program toward being perceived as*

welfare and will weaken public support."

The House GOP bill fails to include a federal "fallback" provision. In the Senate bill, if at least two private plans fail to enter the market in a region, the federal government would step in and offer beneficiaries a Medicare prescription drug benefit. However, the House bill fails to include this critically-important provision. As the AARP points out, *"Experience with the private market raises questions about the availability and stability of private plans in all parts of the country, as well as the variability of premiums. ... It is therefore critical that the bill include a viable, guaranteed federal 'fallback' with a defined benefit and defined premium, where private plan options do not exist."*

The House GOP bill destroys Employer Retiree coverage. The Congressional Budget Office has concluded that 32 percent of employers who are currently providing retiree prescription drug benefits will drop that coverage if the House GOP bill becomes law as written. In order to lower its cost, the House Republican bill stipulates that any dollar an employer pays for an employee's drug costs would not count towards the employee's $3,500 out-of-pocket catastrophic cap. This would therefore disadvantage seniors with employer retiree coverage because it would be almost impossible for them to ever reach the bill's catastrophic cap, over which Medicare would pay 100% of their drug costs. The practical effect of this is that many employers will stop offering retiree coverage. As AARP has stated, *"The Congressional Budget Office estimates that 32 percent of Medicare beneficiaries with existing coverage will lose their employer plan. We urge you to ensure adequate incentives for employers – who are already dropping coverage – to maintain their plans."*

June 26, 2003

TALKING POINTS ON RANGEL-DINGELL SUBSTITUTE TO GOP PRESCRIPTION DRUG BILL

"To those who say that [the GOP bill] would end Medicare as we know it, our answer is: We certainly hope so."

Rep. Bill Thomas, MSNBC, 6/25/03

Democrats have been fighting for years for a Medicare prescription drug program that is affordable; available to all seniors and disabled Medicare beneficiaries; offers meaningful, guaranteed benefits; and is offered within the traditional Medicare program. In contrast, the GOP bill does not make prescription drugs affordable; does not guarantee that the benefit will be available to seniors in rural areas; does not offer a meaningful plan with guaranteed costs and benefits; and does not give seniors the option of obtaining their prescription drug coverage through traditional Medicare.

The rule makes in order a substitute by Rep. Charles Rangel, Ranking Democrat on the Ways and Means Committee, and Rep. John Dingell, Ranking Democrat on the Energy and Commerce Committee. The Rangel-Dingell substitute reflects the four fundamental Democratic criteria for prescription drug coverage outlined above.

Following are talking points on the Rangel-Dingell substitute.

Unlike the GOP bill, the Rangel-Dingell substitute makes drugs affordable for seniors. Unlike the GOP bill, the Rangel-Dingell substitute provides for an affordable monthly premium, a reasonable deductible, affordable co-payments, and a reasonable catastrophic cap on out-of-pocket expenses. The Medicare prescription drug benefit would operate in a manner very similar to the way Medicare Part B operates now – a monthly premium of $25, an annual deductible of $100, and a 20% copayment for drug costs until the beneficiary's out-of-pocket costs reach $2,000, at which point Medicare pays 100%. For example, a beneficiary with $3,000 in annual drugs costs would pay $980 (including premiums) and save $2,020 or 67%. A beneficiary with $5,000 in annual drug costs would pay $1,380 (including premiums) and save $3,620 or 72%. Unlike the GOP bill, there is no coverage gap in the Rangel-Dingell substitute – 80% of drug costs are covered until the out-of-pocket catastrophic cap is reached at $2,000.

The Rangel-Dingell substitute brings down the costs of prescription drugs. The Rangel-Dingell substitute includes three very important provisions to bring down drug costs. First of all, the Rangel-Dingell substitute gives the HHS Secretary authority to use the purchasing power of all 40 million Medicare beneficiaries to negotiate lower drug prices. These reduced prices will be passed on to beneficiaries. (In

contrast, the GOP bill prohibits the HHS Secretary from negotiating lower drug prices). Secondly, the substitute includes provisions allowing the reimportation of FDA-approved drugs from Canada, where they cost much less, for resale in the United States. Thirdly, it includes extensive provisions that would dramatically expand the availability of low-cost generic drugs by closing loopholes used by drug companies to extend their patents (the generic drug provisions in the Rangel-Dingell substitute are stronger and more extensive than those in the GOP bill).

The Rangel-Dingell substitute includes a $39 billion rural health care provider package – $12 billion larger than the GOP bill. The Rangel-Dingell package provides for more equitable Medicare payments for rural hospitals, physicians, skilled nursing facilities, and home health agencies. The substitute includes the same provisions for rural health care providers as the House GOP bill but then goes beyond the provisions in the GOP bill, providing approximately $12 billion in additional relief for rural areas. Key additional provisions in the Rangel-Dingell substitute that are not contained in the GOP bill include: Increased payment floor for rural physicians by increasing work, malpractice, and practice expense adjustments to 1.0 ($5.1 billion); increased payments of up to 25 percent for small, low-volume hospitals ($1.9 billion); increased Medicare DSH funding for rural facilities with no cap ($3.2 billion); and increased assistance of 10 percent for rural home health agencies ($0.3 billion).

Unlike the GOP bill, the Rangel-Dingell substitute provides a meaningful, guaranteed benefit. Under the GOP bill, there is no guaranteed benefit. Instead, private insurance companies would design the new prescription drug plans, decide what to charge, and even decide which drugs seniors would get. GOP sponsors estimate a premium of $35 a month, but premiums would vary – and in Nevada, the only place where drug-only policies have been tried, the premium ended up being $85 a month. By contrast, under the Rangel-Dingell substitute, the prescription drug benefit would operate like all Medicare benefits do today – it's a guaranteed, defined benefit – with a premium, deductible, copayments, and catastrophic cap set in statute and the same nationwide. The Rangel-Dingell substitute provides the reliable, uniform coverage that beneficiaries count on from Medicare.

Unlike the GOP bill, the Rangel-Dingell substitute ensures that the prescription drug benefit is available to everyone on Medicare – including both rural and urban beneficiaries. Under the GOP bill, seniors in rural areas will not have access to the same prescription drug benefits as those in urban areas. Nearly one in four Medicare beneficiaries live in rural counties. And 80 percent of rural Medicare beneficiaries live in an area that Medicare managed care plans have chosen not to serve. And yet the House GOP bill relies on private insurance companies to provide prescription drug coverage. These private plans can decide whether or not to serve rural areas, and they can decide to leave every 12 months. Many rural areas may end up with no drug policy available. If available, rural beneficiaries will end up paying higher premiums. In sharp contrast, as was noted above, under the Rangel-Dingell substitute, the benefit and the premium are set in statute and uniform across the country. Under Rangel-Dingell, rural beneficiaries would have access to the same affordable, guaranteed, meaningful prescription drug benefit under Medicare as beneficiaries living everywhere else in the country.

Unlike the GOP bill, the Rangel-Dingell substitute provides all Medicare beneficiaries the choice of obtaining their prescription drug coverage through traditional Medicare. Despite GOP rhetoric regarding choice, the GOP bill denies seniors the most important choice of all – the choice of obtaining their

prescription drug benefit through Medicare. Instead, seniors would be forced to use private insurance companies for drug coverage rather than Medicare. The Rangel-Dingell substitute provides beneficiaries a true choice – they can stay in traditional, fee-for-service Medicare and receive their guaranteed, reliable benefit through Medicare or they can join a private managed care plan and receive their drug coverage from their private plan.

Unlike the GOP bill, the Rangel-Dingell substitute preserves the traditional Medicare program that seniors know and trust. The GOP bill is specifically designed to privatize the entire Medicare program. Indeed, as noted above, Rep. Bill Thomas has said, "To those who say that [the GOP bill] would end Medicare as we know it, our answer is: We certainly hope so." Not only is the new prescription drug benefit run by private insurance companies, but traditional Medicare itself would soon "wither on the vine." Under the GOP "competitive bidding" provisions tacked onto the prescription drug legislation, Medicare would be turned into a voucher program – rather than a defined benefit program – in 2010. As a result, millions of seniors who want to stay in traditional Medicare would be required to pay much more than they do now. Indeed, the Chief Actuary of Medicare estimated in 2000 that these provisions would raise premiums in traditional Medicare by 47%. In sharp contrast, the Rangel-Dingell substitute preserves and protects Medicare – containing no provisions that would result in the unraveling of Medicare a few years from now.

June 25, 2003

The Honorable Bill Thomas
Chairman
House Ways and Means Committee
Washington, D.C. 20515

Dear Chairman Thomas:

AARP is encouraged by the advancement in the House of legislation to add prescription drug coverage to Medicare. Relief from the high cost of drugs is long overdue. Our members, and all older Americans and their families, expect and need legislation this year. We appreciate your efforts and leadership toward this end.

Several important provisions for a successful benefit are included in the bills pending before the House. These include: a voluntary prescription drug benefit that is available to all beneficiaries; the same benefit subsidy for beneficiaries in both fee-for-service and other Medicare coverage options; assistance for low-income individuals; and a cap on catastrophic health care costs in the new Enhanced Fee-for-Service and Medicare Advantage programs.

Congress is closer than ever to enacting a much-needed drug benefit. However, more needs to be done to ensure that what passes will work in practice and will provide needed relief for beneficiaries. We continue to be concerned with affordability and benefit stability, as well as the long-term implications for the Medicare program.

There are a number of issues that we believe need to be addressed to ensure that the drug benefit can succeed and win the support of our members and other Americans:

- **Premium Support**: We do not oppose the addition of new private plan options in Medicare. However, the provision that would establish a premium support structure beginning in 2010 could destabilize the traditional Medicare program and lead to much higher costs for beneficiaries. We recognize that efforts have been made to mitigate the harmful effects of this provision, but the changes do not correct the inherent problems with this structure. Rather than expand choice, this provision could limit choice by leading to substantially higher costs for beneficiaries who want to stay in the traditional Medicare program. Those who choose not to enroll in private plans should not be put at a financial disadvantage.

- **Adequacy of the Drug Benefit:** Of primary concern is that the coverage be affordable and attractive enough to ensure enrollment of a large enough pool of beneficiaries to allow the program to work. Our research has consistently shown that beneficiaries' enrollment decisions are influenced by the adequacy and complexity of the benefit. While the benefit is attractive for those up to the coverage gap, this gap remains among their top concerns. It is not good policy, is unnecessarily confusing, and will prove to be a disincentive to enrollment. We urge you to close this coverage gap.

- **Indexing:** Another key affordability issue is that benefit levels are indexed to the cost of drugs. Drug costs have been rising at levels well above general inflation. Failure to contain the costs of drugs in the future means that the benefit will rapidly become unaffordable over time. For example, the initial deductible amount of $250 in 2006 is projected to nearly double by 2013. Since older Americans' cost-of-living adjustments are linked to the general inflation rate, they will swiftly fall behind a benefit indexed to drug costs. We urge you to index the benefit level to another measure more closely related to the growth in beneficiaries' ability to pay, to ensure that the coverage will remain affordable over time.

- **Means Testing:** Medicare has always been and must remain a social insurance program. Altering the catastrophic coverage benefit based on beneficiary income would erode the universal nature of the program. Workers pay into Medicare, based on their full salaries, all their working lives. Their support is due to the fact they can depend on Medicare's specified benefit coverage when they retire. Weakening this social contract -- even if it at first only narrowly affects higher income beneficiaries -- threatens to move the program toward being perceived as welfare and will weaken public support.

- **Reliable Federal Fallback:** Whether or not beneficiaries actually have access to an affordable drug benefit depends almost entirely on whether, and at what price, private plans are willing to offer coverage. Experience with the private market raises serious questions about the availability and stability of private plans in all parts of the country, as well as the variability of premiums. While many of our members value greater choices, for most of them the stability of the program is paramount. It is therefore critical that the bill include a viable, guaranteed federal "fallback" with a defined benefit and defined premium, where private plan options do not exist. It also is critical to address the need for equitable premiums across the nation.

- **Retention of Employer-Sponsored Retiree Coverage:** Employer plans are the single largest source of prescription drug coverage for Medicare beneficiaries, covering about 12 million people. Consequently, the bill correctly provides subsidies to encourage the continuation of such coverage. However, the Congressional Budget Office (CBO) estimates that 32 percent of Medicare beneficiaries with existing coverage will still lose their employer plan. We urge you to ensure adequate incentives for employers – who are already dropping coverage – to maintain their plans.

- **Low-Income Protections:** We are encouraged by the bill's inclusion of all Medicare beneficiaries, including "dual eligibles", in the prescription drug benefit. However, the protection for low-income seniors with income above Medicaid eligibility should be improved. Poor and near-poor individuals would pay for all drug costs in the benefit gap, which could be a significant amount of their annual income. In addition, eligibility is limited by a restrictive assets test that keeps otherwise low-income beneficiaries from paying reduced cost sharing. We urge you to improve the protections for low-income beneficiaries.

- **Cost Containment:** The high cost of prescription drugs continues to be a top concern of our members. To ensure the affordability of the benefit for both individuals and the program, greater efforts are needed to put downward pressure on health care costs, particularly the price of drugs. Additional cost containment strategies are needed, including the promotion of generic drugs, development and dissemination of comparative effectiveness information, greater authority for states to negotiate lower prices, improvements in safety, quality and prevention, and chronic care management. We urge you to build in more control over the growth of prescription drug costs.

I also want to reiterate AARP's position on the use of funds from the $400 billion allocation for provider reimbursement increases. Providers should be paid fairly for treating Medicare patients, but beneficiaries have waited long enough for relief from high prescription drug costs. Every dollar allocated to "givebacks" means one dollar less available to improve the drug benefit. Increases in provider reimbursements also substantially increase beneficiary out-of-pocket costs through higher premiums and coinsurance.

We appreciate that objective analyses by MedPAC and others demonstrate legitimate need for some provider payment adjustments. However, we also note that these analyses demonstrate need for decreases in some areas as well. Any reimbursement changes should be based on sound, objective analyses, and result in no net increase that would diminish the amount of funding for a drug benefit or add to total beneficiary cost-sharing obligations.

We are also concerned about the imposition of other cost-sharing requirements – specifically a new copay for home health services. This could create a financial burden for some of the Medicare program's sickest beneficiaries.

AARP members and their families want a prescription drug bill enacted into law this year. We believe that the concerns outlined above can and should be addressed as the bills move forward. Mr. Chairman, we look forward to continuing to work with you to ensure that needed improvements are made and that we enact – this year – the best possible bill to fulfill the promises made to older Americans

Sincerely,

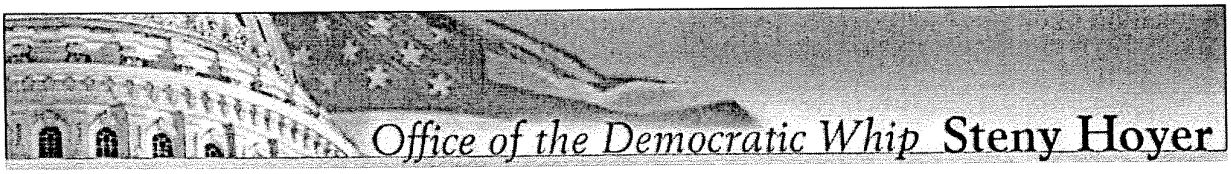
William D. Novelli

William D. Novelli

Medicare Prescription Drug Bill:
Senate Finance vs. House GOP vs. Democratic Proposal

	Senate Bill	House GOP Bill	Democratic Bill
Coverage Gap	**YES - AFFECTING 12% OF BENEFICIARIES** No coverage for drug costs from $4,500 to $5,800.	**YES - AFFECTING 47% OF BENEFICIARIES** No coverage for drug costs from $2,000 to $4,900.	**NO** There is no coverage gap.
Guaranteed Lower Drug Prices	**NO**: *Prohibits* HHS Secretary from negotiating lower drug prices. Private insurers negotiate separately on behalf of subsets of the Medicare population, diminishing group negotiating power.	**NO**: *Prohibits* HHS Secretary from negotiating lower drug prices. Private insurers negotiate separately on behalf of subsets of the Medicare population, diminishing group negotiating power.	**YES**: Uses all Medicare beneficiaries to negotiate lower drug prices. Also reduces drug prices for all Americans, by closing loopholes and expanding the availability of generic drugs.
Guaranteed Minimum Prescription Drug Benefit	**NO**: Beneficiaries are forced to use private insurance companies for drug coverage, rather than Medicare. Although the benefit offered by private insurers has to be "actuarially equivalent" to a "benchmark," benefit and premiums will vary widely.	**NO**: Beneficiaries are forced to use private insurance companies for drug coverage. Although the benefit offered by private insurers has to be "actuarially equivalent" to a "benchmark," benefit and premiums will vary widely.	**YES**: Medicare covers prescription drugs like other Medicare benefits, with guaranteed benefits, premiums, and cost sharing for all beneficiaries who wish to participate.
Begins to Privatize Medicare	**NO**: While HMOs and PPOs are encouraged to compete with each other, traditional fee-for-service Medicare remains.	**YES**: Traditional Medicare program is chopped into 10 or more regional plans in 2006 and then ends as a defined benefit program in 2010.	**NO**: Does not privatize Medicare.
Guaranteed Monthly Premium & Deductible	**NO Guarantee**: Private insurance companies will set premiums; $275/year deductible	**NO Guarantee**: Private insurance companies will set premiums; $250/year deductible.	**BOTH Guaranteed**: Specified in statute. $25/month premium; $100/year deductible.
Catastrophic Coverage	**NONE** Beneficiary has to continue paying 10% copayment once the coverage gap stops at $5,800.	**WEAK** When drug costs exceed $4,900, 100% of drug costs are covered (except for higher-income beneficiaries).	**STRONG** When out-of-pocket costs exceed $2,000, 100% of drug costs are covered.
Coverage for Prescribed Medicines	**LIMITED** Private drug insurers can deny coverage for drugs not in their "formulary."	**LIMITED** Private drug insurers can deny coverage for drugs not in their "formulary."	**YES** Medicare beneficiaries have coverage for all drugs prescribed by their doctor.
Lower-Income Protections	**WEAK** Eliminates Medicare coverage for low-income seniors below 74% of poverty. Gives significant subsidies up to 160% of poverty.	**WEAK** Imposes assets test that may disqualify up to 40% of otherwise low-income beneficiaries. Gives significant subsidies up to only 135% of poverty.	**STRONG** No assets test. No cost sharing or premiums up to 150% of poverty; sliding scale premiums between 150% and 175% of poverty.

Source: Office of Democratic Leader Nancy Pelosi



GOP'S PLAN FOR MEDICARE

"Let It 'Wither on the Vine'"

"To those who say that [the bill] would end Medicare as we know it, our answer is: We certainly hope so."

-Bill Thomas, Chairman of the Ways and Means Committee, MSNBC, 6/25/03

"I believe the standard benefit, the traditional Medicare program, has to be phased out."

- Rick Santorum, Chairman of the Senate Republican Conference, 5/21/03

In 1995, former House Majority Leader Dick Armey said he "deeply resents the fact that when I'm 65, I must enroll in Medicare."

- Chicago Tribune, 7/11/95

Former Majority Leader Armey also called Medicare "a program that I would have no part of in a free world."

- Chicago Tribune, 7/11/95

"Now, we didn't get rid of it in round one because we don't think that that's politically smart and we don't think that's the right way to go through a transition. But we believe it's going to wither on the vine because we think people are voluntarily going to leave it."

- Former House Speaker Newt Gingrich, 10/24/95

"I was there fighting the fight, one of 12 voting against Medicare in 1965 because we knew it wouldn't work."

- Former Senator Bob Dole, 11/11/95